DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **03-12**

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: **Title XIX of the Social Security Act (Medicaid)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2003**

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT

a. FFY '03 $ 375,000
b. FFY '04 $ 1,501,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Pages 12, 115, 116, 117, and 127.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, Pages 12, 115, 116, 117, and 127.

10. SUBJECT OF AMENDMENT:

Critical Hospital Adjustment Payment (CHAP) and children's hospital changes under Attachment 4.19-A.

11. GOVERNOR'S REVIEW *(Check One)*

[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:

Barry S. Maram

13. TYPED NAME: **Barry S. Maram**

14. TITLE: **Director of Public Aid**

15. DATE SUBMITTED

16. RETURN TO:

Illinois Department of Public Aid
Bureau of Program and Reimbursement Analysis
Attn: Frank Kopel, Chief
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 30 2003

18. DATE APPROVED: APR - 5 2004

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

RECEIVED
SEP 30 2003
DMCH - IL/IN/OH

FORM CMS-179 (07/92) *Instructions on Back*

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10/92 b. Be enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program.

2. Rehabilitation Hospitals

A rehabilitation hospital must:

a. Hold a valid license as a physical rehabilitation hospital; and

10/92 b. Be enrolled with the Department as a rehabilitation hospital to provide inpatient rehabilitation services (category of service 22) and have a Provider Agreement to participate in the Medicaid Program.

3. Children's Hospitals

A children's hospital must be either:

07/03 a. ~~Be a~~ A hospital devoted exclusively to caring for children; or ~~. A general care hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality before September 30, 1998, shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children;. A children's hospital licensed by a municipality shall be reimbursed for all Medicaid inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation, regardless of the physical location within the hospital complex where the care is rendered; and~~

b. A general care hospital that includes a facility devoted exclusively to caring for children that meets one of the following definitions:

i. A facility that is separately licensed as a hospital by a municipality prior to September 30, 1998.

ii. A facility that is part of a hospital that has been designated by the State as a Level III perinatal care facility, has a Medicaid inpatient utilization rate (as defined in Section C.8.e. of Attachment 4.19-A) greater than 55 percent for the rate year 2003 disproportionate share determination, and has more that 10,000 qualified children days. Qualified children days means the number of hospital inpatient days for recipients under 18 years of age at the time of admission who are eligible under Medicaid, excluding days for normal newborn, obstetrical, psychiatric, Medicare crossover, and rehabilitation services, as determined from the Department's claims data for days occurring in the State fiscal year 2001 that were adjudicated by the Department through June 30, 2002.

~~b~~c. A children's hospital qualifying under paragraph (b) shall:

i. Have a separate provider agreement to participate in the Medicaid program; and

ii. Be reimbursed for all inpatient and outpatient services rendered to persons who are under 18 years of age, with the exception of obstetric, normal newborn nursery, psychiatric and rehabilitation services, regardless of the physical location of the hospital complex where the care is rendered.

10/92 4. Long Term Stay Hospitals

10/92 A long term stay hospital must:

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received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of the national total hospital market basket price proxies, (DRI), and added to the base year cost per diem, as described in Section B.4. above, which is subject to the inflation adjustment described in Section D. below.

D. Inflation Adjustment For Base Year Cost Report Inflator

1. The base year cost per diem, as defined in Section B.4. above, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in Section B.1. above by the previous year's operating cost per diem.

7/03 2. Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.

7/03 3. Effective July 1, 2003, the rate for hospital inpatient services shall be the rate calculated in accordance with subsections (D)(1) and (2) of this Section, that was in effect on January 1, 2003. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 CFR 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the Social Security Act. Rate adjustments will be conducted in accordance with subsection (D)(3) of this Section.

E. Review Procedure

The review procedure shall be in accordance with Chapter IX.

F. Applicable Inpatient Adjustments

1. The criteria and methodology for making applicable DSH adjustments to hospitals which are exempt from the DRG PPS as described in Section C.8. of Chapter II., shall be in accordance with Section C.7.a. of Chapter VI.
2. The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals which are exempt from the DRG PPS as described in Section C.8. of Chapter II., is described below.

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07/95 a. The payment adjustment shall be $150 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate as described in Section C.7.e. of Chapter VI, exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate as defined in Section C.7.c. of Chapter VI multiplied by 3.75. This payment adjustment is based on a rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.

07/95 b. The amount calculated pursuant to Section F.2.a. above shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:

07/95 i. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

07/95 ii. The percentage increase in the statewide average hospital payment rate, as described in Section C.8.h. of Chapter VI, over the previous year's statewide average hospital payment rate.

07/03 c. The amount calculated pursuant to Sections F.2.a. through F.2.b. above shall be no less than the rate calculated in accordance with Section C.7.b. of Chapter VI in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year, through July 1 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

07/03 d. Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 CFR 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the Social Security Act. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section.

07/95 ed. The amount calculated pursuant to Section F.2. of this Chapter, shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

07/96 3. County Provider Adjustment .

a. Effective July 1, 1995, hospitals reimbursed under this Chapter shall be eligible to receive a county provider adjustment. The methodology used to determine the add-on payment amount is as follows:

07/96 i. Beginning with July 1, 1995, hospitals under this Chapter shall receive $15,500 per Medicaid inpatient admission in the base period.

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07/03 ii. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 CFR 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the Social Security Act. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments if there is allowable room under the State's federal DSH allotment, as determined in Section 1923(f) of the Social Security Act, and under the hospital specific OBRA test, which is conducted to ensure compliance with Section 1923 (g) of the Social Security Act. The amount of the payment that will be classified as DSH will be determined in the following manner:

1. One-half of this quarterly payment will be classified as DSH spending for federal reporting purposes.

2. If the federal upper payment limit cap reduces spending by an amount that is greater than one-half of the quarterly spending, the amount reclassified as DSH will be increased by the amount of the payment reduction that exceeded one-half of the original payment.

3. The amount classified as DSH spending in subsections (1) or (2) will be constrained both by the available funding in the State's federal DSH allotment, and the hospital specific OBRA test.

iii. The payments made under this subsection shall be made on a quarterly basis.

b. County Provider Adjustment Definitions

07/96 i. "Base Period" means State fiscal year 1994.

07/96 ii. "Medicaid Inpatient Admission" means hospital inpatient admissions provided in the base period, which were subsequently adjudicated by the Department through the last day of June, 1995, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns and Medicare/Medicaid crossover days.

07/03 4. Hospitals reimbursed under this Chapter shall receive supplemental inpatient payments. Effective with admissions on or after July 1, 1995, supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in Section B.4. above, as adjusted for restructuring, as described in Section C. above, and as adjusted for inflation, as described in Section D. above, and the calculated Medicaid percentage per diem payment adjustment, as described in Section F.2. of this Chapter, by the hospital's percentage of inpatient charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective July 1, 1995, the supplemental inpatient payments calculated under this subsection shall be no less than the supplemental inpatient rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days. Effective July 1, 2003, the supplemental inpatient rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 CFR 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the Social Security Act. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section.. The supplemental inpatient payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.

7/91 G. Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section F. of Chapter III.

10/92 H. Trauma Center Adjustments . Trauma center adjustments shall be made in accordance with Section E. of Chapter VI.

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10/92 I. Reductions to Total Payments

1. Copayments

Copayments are assessed under all medical programs administered by the Department and shall be assessed in accordance with Section E.1. of Chapter VII.

2. Third Party Payments

The requirements of Section E.2. of Chapter VII. shall apply.

07/03 3. If, during the Department's analysis of the aggregate upper payment limit test, or the hospital specific OBRA test for DSH hospitals, the Department determines that payments described in subsections (D) and (F) of this section, as well as Chapter XV subsection (D)(8), exceed the allowable limits, the Department will make the following payment adjustments:

a. Inpatient payments in Chapter XV subsection (D)(8) will be reduced until total payments no longer exceed the federal UPL and OBRA spending limits.
b. If payments, reduced under subsection (a), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (F)(3) of this Section will be reduced until total payments no longer exceed the federal UPL and OBRA spending limits.
c. If payments, reduced under subsection (b), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (F)(4) of this Section will be reduced until total payments no longer exceed the federal UPL spending limit.

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d. If payments, reduced under subsection (c), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (F)(2)(d) of this Section will be reduced until total payments no longer exceed the federal UPL spending limit.

e. If payments, reduced under subsection (d), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (D) of this Section will be reduced until total payments no longer exceed the federal UPL spending limit.

10/92 J. Prepayment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with Section L. of Chapter VIII.

10/92 K. Cost Reporting Requirements

Cost reporting requirements shall be in accordance with Section G. of Chapter VIII.

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7/03 3. Hospitals qualifying under subsection C.1.b. of this Chapter will receive the following rates:
a. Qualifying hospitals will receive a rate of $421.00 ~~$303.00~~ per day.
b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by $369.00 ~~$262.00~~ per day.

7/02 4. Hospitals qualifying under subsection C.1.c. of this Chapter will receive the following rates:
a. Hospitals will receive a rate of $28.00 per day.
b. Hospitals located in Illinois and outside of HSA 6, that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $55.00 per day.
c. Hospitals located in Illinois and inside HSA 6, that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by $403.00 per day.
d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by $32.00 per day for hospitals that have less than 4,000 total days; or $246.00 per day for hospitals that have greater than 4,000 total days but less than 8,000 total days; or $178.00 per day for hospitals that have greater than 8,000 total days.
e. Hospitals with more than 3,200 Total admissions will have their rate increased by $248.00 per day.

5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:
a. Hospitals will receive a rate of $41.00 per day.
b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.
c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $87.00 per day.
d. Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rates increased by an additional $41.00 per day.

6. Hospitals qualifying under subsection C1.e above will receive $188.00 per day.

7. Hospitals qualifying under subsection C.1.f. of this Section will receive a rate of $55.00 per day.

7/03 8. Hospitals qualifying under subsection C.1.a.iii. above, with respect to payments under this section:
a. ~~w~~Will have their rates multiplied by a factor of two.
b. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 CFR 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the Social Security Act. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section.
c. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments if there is allowable room under the State's federal DSH allotment, as determined in Section 1923(f) of the Social Security Act, and under the hospital specific OBRA test, which is conducted to ensure compliance with Section 1923 (g) of the Social Security Act. The amount of the payment that will be classified as DSH will be determined in the following manner:
i. One-half of this quarterly payment will be classified as DSH spending for federal reporting purposes.
ii. If the federal upper payment limit cap reduces spending by an amount that is greater than one-half of the quarterly spending, the amount reclassified as DSH will be increased by the amount of the payment reduction that exceeded one-half of the original payment.
iii. The amount classified as DSH spending in subsections (1) or (2) will be constrained both by the available funding in the State's federal DSH allotment, and the hospital specific OBRA test.